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PRINTED: 06/13/2009 FORM APPROVED *Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING С B. WING NVS3641HOS 06/02/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9300 WEST SUNSET SOUTHERN HILLS HOSPITAL & MEDICAL CEN LAS VEGAS, NV 89148 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) S 000 Initial Comments S 000 See Exhibit A, "Discharge Planning" This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 05/29/09 and finalized on See Exhibit B, "Discharge Planning 06/02/09, in accordance with Nevada Referrals" Administrative Code, Chapter 449, Hospitals. See Exhibit C, "Assisted Living / Adult Complaint #NV00021536 was substantiated with deficiencies cited (Tag S143, S145, S146, S153). Group Care Homes" Complaint #NV00019281 was unsubstantiated. Complaint #NV00021888 was unsubstantiated. See Exhibit D, "Adult Group Care Complaint #NV00018874 was unsubstantiated. Discharge Planning Tool" Complaint #NV00019723 was unsubstantiated. Complaint #NV00020328 was unsubstantiated. See Exhibit E, "Resident Compliance Complaint #NV00021639 was unsubstantiated. Complaint #NV00016460 was unsubstantiated. Evaluation Tool" Complaint #NV00016019 was unsubstantiated. 8/16/20 The director of case management, A Plan of Correction (POC) must be submitted. Michelle Bogardus RN has written 3 The POC must relate to the care of all patients and prevent such occurrences in the future. The new policies regarding safe discharge intended completion dates and the mechanism(s) titled "Discharge Planning", Discharge established to assure ongoing compliance must Planning Referrals", and "Assisted be included. Living/Adult Group Care Homes". These Monitoring visits may be imposed to ensure policies will be reviewed and approved on-going compliance with regulatory requirements. at the July Policy and Procedure Meeting. The forms "Adult Group Care The findings and conclusions of any investigation Discharge Planning Tool" and "Resident by the Health Division shall not be construed as prohibiting any criminal or civil investigations, Compliance Evaluation Tool" will be actions or other claims for relief that may be approved at the July Forms Committee

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(a) Have a process for discharge planning that

available to any party under applicable federal,

state or local laws.

A hospital shall:

S 143 NAC 449.332 Discharge Planning

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Meeting.

\Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 143	Continued From page 1 applies to all inpatients; and (b) Develop and carry out policies and procedures regarding the process for discharge planning. This Regulation is not met as evidenced by: Based on policy review and interview the facility failed to ensure a policy was in place regarding the safe medical discharge planning of a patient and the patient's needs when a family member, power of attorney (POA) preferred a lower level care for discharge than was needed for the patients. Findings Include: 1. The "Hospital Wide, Admission, Discharge and Transfer" policy, dated 5/08, did not include a "Discharge Guideline" for a patients' safe medic discharge when the family or POA preferred a lower level of medical care than was medically needed/required for the patient. Interviews with the Director of Case Management and a Case Manager were held in the afternoon of 5/29/09. Both interviews indicated they were unaware of facility policies guiding the issue of the family or POA preferring a lower level of care than was required for a safe patient discharge. Both Case Managers were unsure what actions needed to occur to ensure the needs of the patient for a safe discharge.	of d	All case management employees will be oriented to the new policies in an inservice, with a signature of understanding. The in-service will be provided by the case management director and social worker. Ten percent of the patients who have a discharge plan to a skilled nursing facility, long term care, rehabilitation facility, or assisted living/group home will be audited retroactively to ensure the new policies are followed and procedures within the policies are performed. The audits will be performed by the case management director, the social worker, and the registered nurse case managers. The audits performed by the registered nurse case managers will be subject to a second medical record audit by the director of case management or social worker. These audits will begin after the Policy Education In-service is completed.	8/16/2 8/14/2
	Severity: 2 Scope: 1 Complaint #NV00021536			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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If continuation sheet 2 of 9

Michel Joganden

Bureau of Health Care Quality & Compliance

STATEMENT	OF DEFICIENCIES
AND PLAN OF	F CORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

X2) MULTIPLE CONSTRUCTION
. BUILDING

(X3) DATE SURVEY COMPLETED

> C 06/02/2009

NVS3641HOS

B. WING STREET ADDRESS, CITY, STATE, ZIP CODE

SOUTHE	ERN HILLS HOSPITAL & MEDICAL CEN		ST SUNSET SAS, NV 89148	8	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 145	Continued From page 2		S 145	Any discharge to an assisted living	!
S 145	NAC 449.332 Discharge Planning		S 145	facility or group home will be	
SS=D	3 A hospital shall at the services and the			concurrent reviewed/audited by two or	oli la
	A hospital shall, at the earliest possible of hospitalization, identify each patient w	le stage /ho is		more licensed case management	8/16/20
	likely to suffer adverse health conseque	nces		employees, ie. Registered nurses,	
	upon discharge if the patient does not readequate discharge planning. The hosp	ceive		and/or Social Worker, prior to patient	
	provide for an evaluation of the needs re	itar snaii elated to		discharge to such facility.	
	discharge planning of each patient so id	entified.		district to sain facility.	
	This Regulation is not met as evidenced Based on chart review, and interview the	d by:			
	failed to identify a patient was likely to su	: racinty iffer		Evhibit A "Dischause Discusion"	
	adverse health consequences upon disc	harge if		Exhibit A "Discharge Planning"	
	the patient did not receive adequate disc planning for 1 of 9 patients (Patient #8).	harge		• Tag S 143	
	planting for 1 of 5 patients (1 attent #6).			Ç	
	Findings include:			• Tag S 145	
	1. The patient's chart had several entries			- Tow C 146	
	regarding her: "altered mental status", n	eeding		• Tag \$ 146	
	assistance with ADL (daily living skills),	_		• Tag S 153	
	requirement of oxygen, wound treatment of a Foley catheter, the need for a skilled	, the use		3	
	facility, the evaluation by an Adult Group	Care			
	(AGC) stating the patient was not appropriately as a support that level of care, an appropriate formal that level of care, an appropriate formal than the state of the state o	riate for		Eddibia D. ((Disabayas Disayiya	
	that level of care, an evaluation for a Hor Individual Care (HIC) stating equipment	ne for		Exhibit B, "Discharge Planning	
	would be required for safe care in that fa	cility		Referrals"	
	type, increased lethargy, unsafe to be lef alone, "bedfast", "total care", a pureed di	t in chair		• Tag S 143	
	cardiac diet, contractures, confused, alte	eા, a red			
	impaired knowledge, altered gross motor	: 1		• Tag S 145	
	impaired thought process, and was depe feeding.	ndent on		7 0110	
				• Tag S 146	
	The patient was discharged to an AGC.	This .		• Tag S 153	
	patient would not meet the criteria per Sta Regulations for an AGC. In addition, the	ate		• Tag S 153	Ä
1	no documented evidence measures were	put in		. W. 19 30 193. L.	
1	place to address the patient needs for Ox	ygen		a Walt	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies 21ET11

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If continuation sheet 3 of 9

PRINTED: 06/13/2009 FORM APPROVED

 Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING NVS3641HOS 06/02/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9300 WEST SUNSET SOUTHERN HILLS HOSPITAL & MEDICAL CEN LAS VEGAS, NV 89148 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Exhibit C, "Assisted Living / Adult S 145 Continued From page 3 S 145 Group Care Homes" care, Foley catheter care, movement/positioning care, wound care, proper equipment for care. ADL care, diet and nutrition needs, as well as Tag S 143 feeding needs.. Tag S 145 Interviews with the Quality Management Director and the Case Management Director indicated Tag S 146 there was no documentation in the record stating needs were addressed nor planned for. Tag S 153 The Quality Management Director indicated the

S 146

Exhibit D, "Adult Group Care Discharge Planning Tool"

Tag S 143

Tag \$ 145

Tag S 146

Tag S 153

Exhibit E, "Resident Compliance **Evaluation Tool**"

Tag S 143

Tag S 145

Tag S 146

Tag S 153

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Discharge summary and the Consent for transfer sheet goes with the transport. Neither of these contained referrals, prescriptions and patient

4. An evaluation of the needs of a patient relating

to discharge planning must include, without

(a) The needs of the patient for postoperative services and the availability of those services:

previous care setting or making another appropriate placement of the patient after

This Regulation is not met as evidenced by: Based on policy review, chart review, and

interview the facility failed to ensure an evaluation of the needs of the patient relating to discharge

planning included the capacity of the patient for self-care and the possibility of returning to

previous care setting or making another

(b) The capacity of the patient for self-care; and (c) The possibility of returning the patient to a

needs to ensure a safe discharge with no

adverse health consequences.

Severity: 2 Scope: 1

Complaint #NV00021536

S 146 NAC 449.332 Discharge Planning

limitation, consideration of:

discharge,

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If continuation sheet 4 of 9

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	l	PROVIDE

ER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

NVS3641HOS

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

B. WING_

С 06/02/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

9300 WEST SUNSET SOUTHERN HILLS HOSPITAL & MEDICAL CEN LAS VEGAS, NV 89148

	LAS VEG	AS, NV 891	48	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 146	Continued From page 4 appropriate placement after discharge for 1 of 9 patient (Patient #8). Findings include: 1. The Hospital Wide, Patient Care: Patient Assessment/Reassessment" policy, dated 10/06, stated: - page 4 and 5, case Management/Social Services. I.d. The scope of the Case Managers assessment includes "1. Functional and cognitive limits and needs, 4. Post discharge care needs." - page 5, "II Reassessment: a. Each patient is reassessed:2. When there is a change in the discharge plan, 3. When another referral is made by the physician or any member of the healthcare team." - page 5, "III Communication with the Healthcare team: a. The case manager records communication and documents in the interdisciplinary" 2. Hospital Wide Initial Patient Status Assessment, dated 3/2006, pg 2 stated: -C. Nursing staff obtains orders for observation, admission or discharge at appropriate times and based upon medical necessity. -E. Case Management (CM)/Social Services (SS) staff reviews status changes for appropriateness based on interqual criteria for medical necessity and for appropriateness of physician's order.	S 146	Lee Pages 1-4 8/1	2/2009
4-6-1	-H. CM/SS staff provides discharge planning in		<u></u>	, J.,

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. STATE FORM 21ET11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIDENTIFICATION N NVS3641HOS				·	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING				URVEY ETED C 2/2009
NAME OF F	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, S	STATE, ZIP CODE				
SOUTHE	RN HILLS HOSPITAL	. & MEDICAL CEN		ST SUNSET AS, NV 8914	18				
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S 146	Continued From page 5 consultation with the attending physician. There was no documented evidence the Case Manager completed an evaluation that included the the functional and cognitive limits or needs of the patient. There was no documented evidence the Case Manager (CM) completed an evaluation when there was a change in the discharge plan (from a Skilled Nursing Facility, SNF, to an Adult Group Care, AGC, facility) that included the functional and cognitive limits or needs of the patient. The CM documented the daughter made arrangements with an AGC and made transportation arrangements. The CM did not communicate in the notes the needs and abilities of the patient. 3. The patient's chart had several entries regarding her: "altered mental status", needing assistance with ADL (daily living skills), requirement of oxygen, wound treatment, the use of a Foley catheter, the need for a skilled nursing facility, the evaluation by an Adult Group Care (AGC) stating the patient was not appropriate for that level of care, an evaluation for a Home for Individual Care (HIC) stating equipment that would be required for safe care in that facility type, increased lethargy, unsafe to be left in chair		S 146	See P	Pager	1-4		14/200	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

cardiac diet, contractures, confused, altered impaired knowledge, altered gross motor,

The patient was discharged to an AGC. This patient would not meet the criteria per State Regulations for an AGC. In addition, there was

impaired thought process, and was dependent on

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feeding.

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If continuation sheet 6 of 9

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NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP (CODE			
SOUTHERN HILLS HOSPITAL & MEDICAL CEN				ST SUNSET AS, NV 8914	48				
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S 146	place to address th care, Foley cathete care, wound care, place ADL care, diet and feeding needs Physician's orders: 3/9/09 - CM for Dis 3/12/09 - transfer to (SNF), if OK with co 3/13/09 - Group ho care (HIC) home. There was no docudiscussed the level needs with the physician for the family found an interview on 5 not recall if she discussed the Case Manathere was no document of the Case Manathere was no	dence measures were patient needs for Cornor, movement/poroper equipment for nutrition needs, as we charge planning of Skilled Nursing Factorsultants me bed, Home for Information in the CM, cussed with the physical AGC for the patient. Quality Management agement Director indicated in the reconsisted nor planned for. ement Director indicates and the Consent for these documents.	oxygen ositioning care, vell as sility dividual e CM care she could ician that t Director icated and stating atted the or transfer patient is s	S 146	Sec	Pager	1-4	87	14/2009
		orescriptions and the							

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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adverse health consequences.

Severity: 2 Scope: 1

Complaint #NV00021536

of the patient to ensure a safe discharge with no

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If continuation sheet 7 of 9

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3641HOS				(X2) MULT A. BUILDIN B. WING	IPLE CONSTRUCTION			SURVEY LETED C 02/2009
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COLLEGE OF				ST SUNSET AS, NV 891	48			
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S 153	Continued From pa	age 7		S 153			*****	
S 153 SS=D	NAC 449.332 Disci	harge Planning	*	S 153	See pgs	1-4		8/16/200
	patient and any oth for the patient mus	embers of the family her person involved in t be provided with su ecessary to prepare are of the patient.	n caring ich					
	Based on policy re- interview the facility involved in the pos- were provided the i	not met as evidence view, chart review, a y failed to ensure per thospital care of the information necessatic after discharge for the information.	nd rsons patient ry to safely					
	Findings include:							
	reviewed the functi the patient nor the	ocumented evidence onal/cognitive asses medical needs of the facility (an Adult Gro	sment of patient			·		
	AGC and the AGC for the patient. The	ented the daughter can said there was a bea of the patient were of	d available ent if the					
	could not recall if the interview and obtain	n 5/29/09 with the C ne AGC came to the n the needs of the pa e needs of the patier	hospital to atient nor				to the first of th	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

4. The patient was discharged to an AGC. This patient would not meet the criteria per State

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, Bureau (<u>of Health Care Quali</u>	ty & Compliance							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:							(X3) DATE SURVEY COMPLETED		
NVS3641HOS				B. WING					2/2009
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP COD	E			
SOUTHE	RN HILLS HOSPITAL	. & MEDICAL CEN		ST SUNSET AS, NV 8914	18				
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S 153	REGULATORY OR LSC IDENTIFYING INFORMATION)		S 153	See	pages	1-4	8/.	16/200	
	Complaint #NV000								

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. STATE FORM 21ET11

If continuation sheet 9 of 9